UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF OHIO

WESTERN DIVISION

ESTATE OF ROGER D. OWENSBY JR., et al.,	:	
Plaintiffs,	:	
vs.	:	Case No. 01-CV-769
	:	(Judge S. A. Spiegel)
CITY OF CINCINNATI, et al.,	:	
Defendants.	:	

VOLUME I

Deposition of DANIEL L. SCHULTZ, M.D., a witness herein, called by the plaintiffs for cross-examination, pursuant to the Federal Rules of Civil Procedure, taken before me, Wendy Davies Welsh, a Registered Diplomate Reporter and Notary Public in and for the State of Ohio, at the Frank P. Cleveland, M.D. Institute of Forensic Medicine, Toxicology and Criminalistics, 3159 Eden Avenue, Cincinnati, Ohio, on Wednesday, December 17, 2003, at 11:57 a.m.

APPEARANCES:

On behalf of the Plaintiffs:

Paul B. Martins, Esq.
Helmer, Martins & Morgan Co. LPA
Suite 1900, Fourth & Walnut Centre
105 East Fourth Street
Cincinnati, Ohio 45202
Phone: (513) 421-2400

John J. Helbling, Esq.
The Helbling Law Firm, L.L.C.
3672 Springdale Road
Cincinnati, Ohio 45251
Phone: (513) 923-9740

On behalf of the Defendants City of Golf Manor, Stephen Tilley, Roby Heiland and Chris Campbell:

Wilson G. Weisenfelder, Jr., Esq.
Rendigs, Fry, Kiely & Dennis
900 Fourth & Vine Tower
One West Fourth Street
Cincinnati, Ohio 45202-3688
Phone: (513) 381-9200

On behalf of Defendants City of Cincinnati, Darren Sellers, Jason Hodge:

Geri Hernandez Geiler, Esq.
Assistant City Solicitor
Department of Law
Room 214, City Hall
801 Plum Street
Cincinnati, Ohio 45202
Phone: (513) 352-3346

Neil F. Freund, Esq.
Freund, Freeze & Arnold
One Dayton Centre
1 South Main Street, Suite
1800 Dayton, Ohio 45402
Phone: (937) 222-2424

APPEARANCES (Continued):

On behalf of the Defendants Robert B. Jorg, Patrick Caton, Jason Hodge, Victor Spellen and Darren Sellers:

Donald E. Hardin, Esq.
Hardin, Lefton, Lazarus & Marks, LLC
915 Cincinnati Club Building
30 Garfield Place
Cincinnati, Ohio 45202
Phone: (513) 721-7300

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S T I P U L A T I O N S

It is stipulated by and among counsel for the respective parties that the deposition of DANIEL L. SCHULTZ, M.D., a witness herein, called by the plaintiffs for cross-examination, pursuant to the Federal Rules of Civil Procedure, may be taken at this time by the notary; that said deposition may be reduced to writing in stenotype by the notary, whose notes may then be transcribed out of the presence of the witness; and that proof of the official character and qualifications of the notary is expressly waived.

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E X H I B I T S

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a small, three eighths of an inch, red abrasion. The right frontal aspect of the scalp had a collection of vertically oriented, short, red abrasions. The right cheek had a collection of red abrasions.

The right aspect of the upper lip had a collection of red abrasions. The upper lip was slightly swollen. The inner aspect of the right side of the lower lip had a sixteenth of an inch, shallow laceration.

The right eye had significant inferior scleral hemorrhage and conjunctival hemorrhages. Several petechiae were seen in the conjunctiva of the right eye. The left eye had a few scattered petechiae. The inferior aspect of the left sclera had some hemorrhage as well.

Q. Let me stop you there for a second. Would you explain some of the terms that you use here. The sclera hemorrhage, explain that, please.

A. Scleral hemorrhage can happen from a couple ways. One, it can happen from compression of the neck or chest with prevention of flow of blood out from the head and neck back into the chest cavity. It can happen from those vessels rupturing.

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The scleral hemorrhage can also, those confluent areas, can also happen from, say an impact to the eye. And I recognize that, but I take them in the company that they keep, and that is, they're surrounded by the tiny, little, dot-like petechial hemorrhages in the eyelids and conjunctiva, the inner pink area of the eye.

So in the company that they keep with the petechiae, I consider them more likely due to increased venous congestion of the head and neck.

Q. Did you take any photographs of the petechiae that you just described?

A. Yes.

Q. There are Bates numbers on the photographs that comprise Exhibit 105. Would you identify the, by Bates number, the photographs that exhibit the petechiae?

(Mr. Helbling entered the deposition hearing room.)

A. The identifiers are P0000259, 260 and 261.

On 259, the first of the group, that's P0000259, you can see I've lifted his eyelid on the left, the upper eyelid. And although I don't think this photograph does great justice to it, there's a little red dot you see above the iris, brown iris. It's at 12:00 if you're looking at the iris, okay. That's a petechial hemorrhage. Not so well photographed in that.

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However, in P0000260, in the right eye, and as I indicated, they were more florid on the right. On the right you see various small red hemorrhages above the iris, the brown area of the eye. Then on the, I would call on the nine to 10:00 aspect, you see this area of brown reddening or brown coloration. That is due to hemorrhage of the sclera.

Q. On 261, what does 261 show, if anything?

A. 261 shows the right eye, and I have pulled the right lower eyelid down to show hemorrhage of the inner aspect of the right lower eyelid and some hemorrhage which is evident on the sclera, or the white part of the eye.

Q. Thank you, Doctor. Then we proceed on with other findings that you made.

A. I think I've already spoken about the eyes.

Q. Yes.

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A. I ended by describing the interior aspect of the left sclera had some hemorrhage.

The oropharynx of the throat contained some thin, tan-white, starchy food material (emesis) consistent with that seen within the stomach. The nostrils also contained a small amount of tan food material (emesis).

So they both were compared with what I see in the stomach. In light of the fact that they looked the same, I consider that emesis rather than just mucus.

Q. By emesis?

A. Vomit. It's a small -- the airway is not packed with this food material, which certainly is a potential cause of death if the person has an obstruction of their airway from this. And I did not appreciate that in the airways or in the throat or in the oral cavities.

Q. You also describe in your report, on the second page, some injuries to the torso including some abrasions. I'd like you to address, on the bottom of the second page you talk about the posterior neck examination being performed. Would you cover that for us?

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A. I made an inverted T-shaped incision extending from the back of the head down below the shoulder blades to look for any hemorrhage or injury. And when I did that, in the, basically, the rhomboid muscles which are between the scapul-- overlie the scapulae, there were hemorrhages.

Now, there weren't any bruises or abrasions noted on the skin of the back, and there wasn't any significant appreciable hemorrhage in the fatty tissues of the back, but it was localized fairly symmetrically within those deep muscular tissues over the scapulae.

So my interpretation of that is a deep injury to the muscles, causing tearing of blood vessels in those muscle groups resulting in the hemorrhage. Because I don't have any pattern injuries, marks, abrasions, contusions on the skin overlying these deep muscular injuries, my interpretation is that they're more likely due to a localized pressure and like a grinding or localized pressure placed on those muscle groups rather than an impact, a direct impact.

Q. If it was a direct impact, say by a nightstick or a punch, would you expect to find

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contusions in the skin or the subcutaneous level of the skin above those deep muscle bruises?

A. I would expect to see any one of these combinations: Either some abrasion to the skin, some bruising to the outside of the skin, some bruising, hemorrhage in the subcutaneous fat.

Because in light of the magnitude of the hemorrhage in those muscle groups, it's not a trivial injury there, and it's remarkable to me that I don't see anything overlying it. So that is why I favor that those injuries to the muscle groups are not due to a blow or blows.

Q. Did you document this finding in the photographs that you took?

A. Yes.

Q. Would you point those out for us? You can just refer to the last three digits.

A. Yeah. 265 through 270 all document various portions of the neck dissection and back dissection. The hemorrhages in the muscle groups are shown in 265, 266, 267, 268, and 269. 270 shows an extension of that incision to look for further hemorrhage in the lower aspect of the back, which I did not appreciate.

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Q. If we look at 267, am I correct in understanding that the blackened or darkened portions in the area of the shoulder blades on either side are the contusions?

A. Yes.

Q. You measured these and they were between three and four inches in diameter?

A. Yes.

Q. Your findings, and in this respect do you make those findings within a reasonable degree of medical certainty in the field of pathology?

A. Yes.

Q. Let's move on. You then, in your report on page 3, you talk about the lungs being "extremely congested and edematous." Do you see that? It's after the first paragraph. It's one line on page 3.

A. Are we in the respiratory system?

Q. No. Up above where it says --

A. Body cavities?

Q. You have a heading of Upper and Lower Extremities, and then right above that.

A. Oh. Yes.

Q. Would you explain that for us?

A. The reason it's listed in that area,

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although heavy lungs, congested lungs, are technically a nonspecific finding, meaning you can see it with other things, he doesn't have any other things to explain it. Meaning, he doesn't have -- he didn't die from heart disease, he didn't die from pneumonia, he didn't die from drug intoxication, which all can cause heavy edematous lungs.

But the only thing he has in the constellation of the findings are petechiae, evidence of compression of his back, evidence of an asphyxial death. The lungs in asphyxia typically become congested and edematous. And so that is why that is listed in that area, because it's technically -- it's an associated finding. That's why it's listed there.

Q. Where are the lungs in relation to the deep muscle hemorrhages that you found?

A. Well, they're in the chest cavities. They're not directly -- it's not because they're contiguous with that area.

It's just when a person dies from an asphyxial death, meaning they're not getting adequate oxygen supplied to their brain and their organs, the heart works faster, blood is pumped to

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the lungs, there's an attempt by the body to have, in response to this, increased oxygen exchange and more flow to the lungs. Subsequently, that flow leads to swelling and edema, which is water on the lung, essentially. They're heavy.

Q. We then have your examination of the body cavity on the internal examination. Is there anything remarkable in that paragraph there about the body cavity concerning these findings?

A. Well, there were a few rare petechiae, and those are nonspecific, on the heart, the surface of the heart. You can see those in a lot of things. So those are specifically listed in that area because I consider them not -- nonspecific.

He was congested. That's, again, nonspecific. But in light of what the big picture is, it's consistent with what he died from, which is an asphyxial event.

Q. You then examined the cardiovascular system. The heart weighed 395 grams. Is that what you would expect for a normal heart of a person this age?

A. Yes.

Q. Why is it that in conducting an autopsy

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the various organs are weighed?

A. Well, the organs are weighed because we look at reference values or we have certain reference values that we have known to come to accept as reasonable weights for various organs.

Probably the most important organ to weigh is the heart. The other organs -- and the lungs. The other organs probably don't matter so much. But it's just another element of documentation that we use to describe a body.

Q. If the organ is outside of the expected weight, is that some sort of signal to investigate further?

A. Well, if, for example, I -- I had found, for example, that there was an enlarged heart and/or coronary artery disease of significant degree that would explain his death and the circumstances then, depending on how the circumstances pan out, then opinions might change.

So every organ is looked at individually and in light of the total body exam, and then I make an opinion overall as to the terms of the cause of death. But no one organ stands alone, generally. You interpret them in light of everything else.

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Q. In the paragraph on the cardiovascular system examination you talk about the descending coronary artery having a 50 percent obstructive plaque situated in the mid portion. Do you see that?

A. Yes.

Q. In your opinion, to a reasonable degree of medical certainty in the field of forensic pathology, did that play any part in causing the death of Mr. Owensby?

A. No.

Q. Why not?

A. Because the 50 percent obstructive -- first of all, I have never had anyone die from a lesion of 50 percent, okay.

Second of all, most forensic pathologists, certainly that I have worked with, trained with, they like to see lesions above 75, roughly 70, 75 percent obstructed before they would even consider that as a cause of death. And if you were to have that kind of lesion, you would then take that in context of the circumstances. But his doesn't even come close to that level.

I did put a section in microscopically,

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which, you know, when we look at things microscopically you take something you see with your naked eye that, as you look at it, you say it's 50 percent. Subsequently, an histologist takes that, cuts little pieces off to look at it on a slide and it never gets worse than what you see with your naked eye, but sometimes it gets better. Meaning the lesion sometimes looks less obstructive. And that's not surprising.

So typically what I say when I look at cases like that is I always know what my gross impression is, which is my naked eye. I will either say it's consistent with, or if it comes out and there's nothing on there, I'll put another section in or I'll figure out why.

But in his case, his histology was consistent with what I saw, namely, he did have an atherosclerotic plaque, but it certainly wasn't more than 50 percent obstructive.

Q. Is there anything else about the cardiovascular system, any findings one way or the other that are worth, or contribute to your opinion in this case?

A. Grossly and microscopically on examination

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of his heart, cardiovascular system, I did not find anything that would have caused or contributed to his death.

Q. Let's move on to the respiratory system, which we already talked about with the lungs being congested. You said that the lungs weighed 860 grams and 765 grams respectively, the right and left lungs. Is that above what you would normally expect a lung to weigh?

A. Yes.

Q. What is the normal weight or range of weights?

A. There is no one normal weight, but I can tell you that generally, normal lungs that aren't congested weigh roughly around two to 400 grams, roughly.

I don't really pay attention to charts where I say, "Oh, I" -- this is clearly well above. This is just very heavy. From my standpoint and experience it's very evident that they're heavy.

Q. You then talk about a maroon-purple congested appearance. If the lungs were not congested, a normal healthy lung, what would you expect the color to be of the lungs?

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A. If it's a person who is not a smoker I would expect them to look pink-tan in color. If they're a smoker I would expect them to look pink-tan with some black and green soot in the lungs.

I didn't appreciate soot in his lungs, but they were very purple and congested, and it's entirely possible there had been evidence of that as well, but I couldn't see it.

Q. Do you know what causes the maroon-purple color in the lungs?

A. Blood.

Q. So it's blood leaching or --

A. Well, it's not -- certainly there can be -- let me refer to my micro so I speak -- okay.

The purple color, maroon coloration, is due to a combination of things. It's due to the vessels that supply what are called the septae of the lungs. Because there are air sacs. And those air sacs are surrounded by septae, which is where the vessels come in to supply the blood. Those vessels become intensely congested and they're distended and dilated with red blood cells.

Now, in a person who doesn't have a

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congested pulmonary vascular circuit their lungs look tan-pink because their vessels aren't distended. When they become distended with blood cells the whole lung or whatever area's involved will have a maroon-purple color.

In addition, there's some additional coloration changes, because there's some hemorrhage in the alveolar air spaces. And that's due to the increased pressure, and it actually leaks from those capillaries into the air sacs of the lungs.

Q. So in a case such as this with asphyxia, the heart is pumping more blood into the lungs to try and get more oxygen for the body?

A. Yeah, it's trying to get -- the body as a response to the hypoxia, or the lack of oxygen, is to try to pump more blood through the heart and pick up more oxygen and transport it to the rest of the body.

Q. If the lungs can't expand to provide that oxygen then the blood keeps coming into the lungs, and is that where you have the edema and the -- resulting in the maroon-purple color?

MR. FREUND: Object.

A. Yes.

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MR. FREUND: I guess, I never did ask you. Is this supposed to be for purposes of trial? If it is, you're leading the witness.

MR. MARTINS: Okay. I'll rephrase it.

BY MR. MARTINS:

Q. Could you explain to us the process, the physiological process, that's going on that results in the maroon-purple color?

A. Well, as I said earlier, in response to the low oxygen, the hypoxia, the cardiovascular system shunts blood to the lungs. Blood is pumped through the lungs in an attempt to pick up more oxygen. The lungs become congested. They may also leak some red cells and/or fluid, edema fluid, into the lungs, and that is the reason for this occurrence.

Q. Is there anything else in the respiratory system examination that is worth noting in respect to your ultimate findings here?

A. Pertinent negatives are that I did not see any emboli, which are, like thromboemboli, which are blood clots that may come from the legs, which are referred to as pulmonary emboli. I did not see any of that. It's another possible natural cause of

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The tongue section was taken and it confirmed my gross impression. There was hemorrhage in the tongue, no inflammatory reaction. It was a bite mark to the tongue, hemorrhagic bite mark to the tongue.

Q. On the last page are some laboratory results. Again, I guess, confirming what you've already said, that there was no cocaine or you have metabolites. What are metabolites?

A. Well, metabolites are what happens to a drug or a chemical after the body has metabolized it. So it's, after metabolism, it's what the drug becomes.

Q. Cannabinoids, that would be the marijuana?

A. Yes.

Q. As I understand it, the finding on the marijuana was 16 thousandths of a milligram per liter?

A. Correct.

Q. Am I reading that correctly?

A. Yes.

Q. As a result of this, did you reach an opinion as to the cause of death of Mr. Owensby?

A. Yes.

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Q. What was your opinion to a reasonable degree of medical certainty in the field of forensic pathology, as to the cause of death of Mr. Owensby?

A. Cause of death, mechanical asphyxia.

Q. Would you explain to us what mechanical asphyxia is?

A. Well, it is a form of asphyxia that is due to physical compression of the chest. And although -- I use it in a rather broad form. Although I recognize that I could be seeing this constellation of symptoms from, or findings from, compression of the chest, I can also see it from compression of the neck.

Now, I use the broad term "mechanical asphyxia." You will find that there is varying definitions of this term. My definition is, it's from a compression of the body in some locale, whether it's chest or neck, resulting in asphyxia.

I don't think either of those scenarios are mutually exclusive. Both or one of those two certainly could have taken place. But in any event, it's still a mechanical pressure applied, resulting in asphyxia.

So, you know, I hope that my term is more

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descriptive.

Q. On Exhibit 103, the first page, where your opinion is listed, under mechanical asphyxia you have listed three sub-headings. Did you mean those to, I guess, explain how you arrived at your mechanical asphyxia opinion?

A. I list those there because I think those are part and parcel to the criteria that I might use to bolster my opinion that this is, in fact, a mechanical asphyxia.

Q. That would be the hemorrhages found in the eyes?

A. Right, the conjunctival petechiae with the scleral hemorrhages, terminal emesis or terminal vomiting. Very commonly seen when a person is hypoxic, they may vomit. In fact, that's very common. And the hemorrhagic bite mark, whether that's from a seizure or whether that's from biting his tongue during the process of the restraint, I don't know. But I list it in that area as well, because it's part of the terminal events, I feel.

Q. Does the congestion of the lungs also support the finding of mechanical asphyxia?

A. Sure.

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Q. How so?

A. Because, as I said, with an asphyxial death one expects the lungs would be rather congested. It's -- well, in terms of what I decide to actually list under that heading, I probably could list more or less. It's the art of listing these things on the diagnosis list. It certainly could have been listed there as well.

Q. Let me ask you, did you see anything that was inconsistent with mechanical asphyxia?

A. No.

Q. You also list several other items under diagnosis, which I believe we've already talked about, the abrasions, the deep back muscular contusions, the facial abrasions and knees and forearm. And then the cause of death you list is mechanical asphyxia. You also have a heading of Manner of death. Would you explain to us the difference between a cause of death and a manner of death?

A. Manner of death is how the cause came about.

Q. Here you wrote, "Homicide," and then in parenthetical phrase,"(police intervention:

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Q. 255?
A. 255 shows a very faint pattern -- not a pattern, faint abrasion of the chest, below the left breast area. I say "not a pattern" because it doesn't have anything that strikes me as being due to a specific object.
Q. 256?
A. 256 is viewed from the right side of Mr. Owensby's head. You can see the right cheek with abrasions. You can see the upper lip. Note, the right aspect of the upper lip has been shaved. I shave the mustache away in order to show the abrasion to the right aspect of the upper lip. And then you also see the abrasions of the forehead.
Q. 257?
A. 257 is viewed from the left side of Mr. Owensby's head, and it shows the abrasions to the forehead.
Q. And 258?
A. 258 is a view of Mr. Owensby from the front showing the abrasions to the forehead, showing the mustache which has been shaved, showing the abrasions to the right aspect of the upper lip, showing a slight amount of this emesis material in

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the nostrils. And that's about it.
Q. With respect to the finding of the deep musculature contusions in the area of the shoulder blades, would those contusions be consistent with a person weighing approximately, with equipment, 270 pounds, kneeling on Mr. Owensby's back?
MR. HARDIN: Objection.
MS. GEILER: Objection.
A. It could be, yes.
Q. It could be consistent with that?
A. Right. It's not inconsistent. It's consistent.
Q. If that person had their arms or arm around the head of Mr. Owensby and were pulling the head back while kneeling on the back, would these injuries be consistent with that also?
MR. HARDIN: Objection.
MR. FREUND: Objection.
A. They are consistent.
Q. I take it from the analysis of the blood, the blood analysis, you found, with the exception of the traces of marijuana, you found no presence of any other drugs?
A. Correct.

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Q. And no traces of alcohol?
A. Correct.
Q. Since conducting your post-mortem exam, you have testified in two trials, one of officer Jorg and one of Officer Caton. As a result of either reviewing documents in preparation for those trials or since those trials, have you seen anything to alter the opinions that you gave in your report here that we've examined today?
MR. FREUND: Objection.
A. No.
Q. Cause you to change your opinions?
A. No.
Q. In this kind of death, a mechanical asphyxiation death, does it occur immediately or does it take a period of time to occur?
A. It takes minutes.
Q. In the case of Mr. Owensby, with a mechanical asphyxia death, then can you say within a reasonable degree of medical certainty in the field of pathology that his death would have taken a number of minutes?
A. Yes.
Q. Are you able to quantify either the range

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of minutes or how many minutes would have been involved?
A. No.
Q. Can you describe for us, beginning with the compression that starts this asphyxia through the time of death, what the body would experience?
A. Well --
MR. FREUND: Object.
A. Aside from the struggle, the first thing that happens is the person loses consciousness.
MR. MARTINS: Hold on a second.
MR. FREUND: He answered the question. That was the point of my objection. The way you asked the question, the patient -- the person could have been unconscious.
MR. MARTINS: Okay.
Q. Describe the process, from when the compression first starts through death, what happens to the person's body? What processes come into play?
MR. FREUND: Objection as to the form of that question.
A. Well, all I can say is with this type of death there are, of course, attempts to breathe.

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The heart picks up the heart rate, because breathing attempts are not able to be -- are not satisfactory. And lungs are given more blood to attempt to obtain more oxygen. The person dies.

Now, the exact sensation that a person would have and that type of thing, frankly, I don't know. I've never experienced it. I'm not aware of any studies that show exactly. But I know the person would become unconscious. And I know there was a struggle. But exactly how long those things lasted, I don't know.

Q. From time to time I've seen the term "hypoxia," and if I'm saying this correct, "anoxia."

A. Yeah.

Q. What's the difference between those two terms? Or is there?

A. Anoxia means no oxygen. Hypoxia means low oxygen.

Q. Hypoxia means low oxygen.

A. Frankly, there's probably no such thing as "anoxia," unless you're on another planet that doesn't have oxygen at all. But generally, they're tossed around in the same manner. They're both low oxygen, generally speaking.

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Q. On the first page of your report, Exhibit 103 -- actually, I guess the first page is the opinion -- the first page of the post-mortem examination, on the exterior of the body examination you list Mr. Owensby as having white shoes. There are other documents that indicate he was wearing brown Timberland shoes. Do you have any explanation or understanding as to how the white shoes entered the report?

A. My most -- I can only recall what I have written. I don't remember off the top of my head. If I thought that was what it was, that's what I thought.

I can tell you though, because they came in a separate bag and we pulled them out to look at them, if I were to explain that discrepancy in the best way, I would suggest that I mistakenly called them white if they were, in fact, brown.

But I don't have any photos to look back on to recall, to jog my memory, but at the time when they were pulled out of the bag and I looked at them, that's apparently what I wrote down and what I thought they were.

Q. Are you familiar with Dr. Cyril Wecht?

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A. Yes.

MR. FREUND: I'm going to object.

Q. Have you been provided a report from Dr. Wecht concerning the death of Mr. Owensby?

MR. FREUND: Object. Can I have a continuing objection, Mr. Martins?

MR. MARTINS: Yes.

A. You gave me a copy of the report on November 8th.

Q. Did the City provide you with one before that time?

A. Before that time?

Q. Yes.

A. No. They came after the fact.

Q. No, no. Before I saw you.

A. No. Because, frankly, I wouldn't change my opinion based on what another pathologist thinks. Because, number one, I had first dibs of looking at the body. He's limited a little bit, because he doesn't get to see it firsthand. But -- so it wouldn't change my opinion.

I don't have any problem with someone looking at it. I'm happy to hear what other people have to say. But no, I wouldn't expect to be

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provided a copy.

Q. My only question is whether, between November -- or in the year 2002, whether or not someone from the City or the Hamilton County provided you with a copy of Dr. Wecht's report?

A. Not that I recall.

Q. Until the time, a couple weeks ago, when I met with you and provided you with a copy, had you seen Dr. Wecht's report?

A. No.

Q. In these minutes that it takes for death to occur due to mechanical aspyxiation you indicated that the person would at some point become unconscious. Would they then at some point after that go into a coma?

MR. HARDIN: Objection.

MR. FREUND: Objection.

A. I think that is one in the same.

Q. And then death. Can you say whether or not, when the officers picked up Mr. Owensby off of the ground and took him to the Golf Manor cruiser and placed him in the cruiser, whether or not he was unconscious or dead? Can you make a distinction between the two based on your examination of the